**Staff working with Respiratory Sensitisers – Annual Assessment**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Surname: | | |  | | Mr / Mrs / Miss / Ms / Dr / Prof | | |
| First names: | | |  | | Date of Birth | |  |
| Status: | Research staff / Technical staff / Undergraduate / Postgraduate / Academic Visitor / Other | | | | | | |
| Job title: | |  | | Supervisor: | |  | |
| Department: | |  | | Internal tel: | |  | |
| Mobile: | |  | | Email: | |  | |

*If you have not been exposed to respiratory sensitisers since your last health questionnaire, please go straight to question 5.*

**1. Employment History**

|  |  |  |
| --- | --- | --- |
|  | At the University of Cambridge | In your career |
| How long have you worked with respiratory sensitisers? – *e.g., chemicals, dust, fumes, etc*. |  |  |

**2. Work Information**

Which respiratory sensitisers are you working with? – *please list below (refer to COSHH risk assessment)*

|  |  |
| --- | --- |
| Name of substance |  |
| Frequency of use |  |
| Duration on each occasion |  |
| What control measures are in place – *e.g., fume cupboard, LEV etc*.? |  |
| What personal protective equipment is worn? |  |

**3. Medical History**

Please answer all the following questions. If ‘yes’ please give dates and details.

**Have you ever been affected by:**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Yes** | **No** | **Date and Details** |
| Asthma or recurrent bronchitis? |  |  |  |
| Allergic rhinitis or conjunctivitis? |  |  |  |
| Hayfever? |  |  |  |
| Eczema / dermatitis? |  |  |  |

**4. Do you have or have you ever experienced any of the following symptoms since working with respiratory sensitisers?** *Do not include isolated colds, sore throats, flu or chest infections.*

If ‘yes’ please give dates and details.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Yes** | **No** | **Date and Details** | |
| Recurring blocked or running nose |  |  |  | |
| Watery, itchy eyes |  |  |  | |
| Bouts of coughing |  |  |  | |
| Wheezing / difficulty in breathing |  |  |  | |
| Chest tightness |  |  |  | |
| Do you use an inhaler to help you breath? |  |  |  | |
| Do you smoke? |  |  | If yes how many? |  |
| Are you an ex-smoker |  |  | If yes when did you stop? |  |

**5. If you no longer work with respiratory sensitisers when did you stop and why?**

|  |  |  |  |
| --- | --- | --- | --- |
| Date: |  | Reason: |  |
|  | | | |
|  | | | |
|  | | | |

**6. Declaration**

I certify that all the answers given above are true to the best of my knowledge and belief.

|  |  |  |  |
| --- | --- | --- | --- |
| Signed: |  | Date: |  |

**For OHS use only**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Suitable to continue working with respiratory sensitisers | | | | | Yes  No |
| Annual recall | | | | | Yes  No |
| Remove from recall | | | | | Yes  No |
| OHA appt | | Yes  No | OHA appt arranged | | Yes  No |
| OHP appt | | Yes  No | OHP appt arranged | | Yes  No |
| Enhanced health surveillance *(Please specify)* | | | | | |
| 3 months | 6 months | | 12 months | other \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |

Clinic nurse / OHA signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name / Stamp \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_